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Barriers and Facilitators for Utilization of Antenatal Care services in Meghalaya state, India

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Abstract
Introduction: The Government of India has expanded the antenatal care services but utilized poorly.. The present paper discusses the situation in Meghalaya state, in northeast India known for low health status
Methods: A house-to-house interview survey was done in South West Khasi Hills district in Meghalaya during 2018-2020, on a random sample of 539 pregnant women.. after obtaining informed consent. Data were computerized and analyzed using SPSS
Findings: More than half (59.4%) of women poorly utilized the antenatal care package although aware of such services. due to deficiencies in functioning of health system and alleged barriers towards utilization. Although a quarter of women experienced health problems during their pregnancy most of them did not seek the help of the HC staff citing multiple reasons. Although aware, most women did not get benefit from maternal entitlement since they didn't have the MCP card and BPL card, no bank account, no voter ID, incomplete check up, or felt the amount too small
Conclusions : Utilization of antenatal care services is poor due to multiple factors in Meghalaya. Proper education and counselling , motivated staff, adequate stocks of essential supplies will help in better utilization.. (192 words)
Keywords: Antenatal care utilization, knowledge, attitudes, Health Centre Meghalaya

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I. INTRODUCTION

Incorrect ,inadequate and untimely antenatal care is still a major problem in reducing maternal and infant mortality in indigenous populations especially in low and middle income countries.(Titaley et al 2010; Rahman et al 2017; Tekelab et al 2019;Ogbo et al 2019) Several investigations on barriers to antenatal care and factors associated with low utilization rates of essential antenatal services have been done but scarcely in northeast region of India which has a dubious reputation of highest maternal and infant mortality rates(Datta et al 2019; IIPS 2017;Banke-Thomas et al 2017). Most indigenous populations are characterized by high poverty, low illiteracy and adverse environmental hygiene practices(Perris et al 2008). Typically, these factors are also associated with low utilization rates of modern antenatal and child care services(Adhikari et al 2016; Simkhade et al 2008). Effective public health action is not possible without a precise description of the pathways in which a variety of socioeconomic,medical, clinical and cultural factors lead to timely and adequate antenatal care, counselling and necessary remedial actions to prevent adverse maternal and fetal outcomesKumar et al 2014). Given the dearth of scientific evidence on these aspects, a major doctoral research was done during 2017-19 in a typical part of Meghalaya state, the South West Khasi Hills district, taking a large representative sample of pregnant and recently delivered women to mainly assess the knowledge, attitudes and utilization rates of antenatal care and their association with relevant socioeconomic, cultural and medical factorsUnderstanding the factors from the study is important in order to reduce the existing gaps that create among health care providers and pregnant women and more importantly to be able to deliver services effectively.(Pallikedavath et al 2013) The findings of the study will be helpful in providing facts to the policy makers and planners of reproductive health for effective strategies and interventions towards improvement of maternal health in the District.

II. MATERIAL AND METHODS

Meghalaya state is situated in the Northeast India withShillongas its capital . According to Govt.of India census 2011, it has a population of 29,66,889 persons of which 14,91,832 are males and 14,75,057 are females. Meghalaya has a literacy rate of 74.43% (Males 75.95% and 72.89% females), 70.3% of the population practicing Christianity and is a tribal state historically following the matrilineal system. Health indicators show

that Meghalaya state has a high MMR which stands at 211 in 2015-16 and also has one of the highest Infant Mortality Rate (IMR) amongst the smaller states in the country (SRS Bulletin, 2011).From the eleven districts of Meghalaya, South West Khasi Hills district was purposively chosen as a typical area for this research. Assuming a Birth Rate of 35 per 1000 population, and further assuming that only 20% utilize the available maternity service, with a type I error of 5%, power of 80% and a precision of 20%, a minimum sample size of 800 pregnancies (400 from each block)was decided.Of 809 women examined, 539 were pregnant at the time of interview, which forms the basis of this paper.

III. RESULTS

Of 539 pregnant women, nearly half(269) were in their second trimester of pregnancy, 10% (56) in their first trimester and 39.7% (214) in their third trimester.188 (35%) are living in villages where there exists a government health centre or sub-centre.

Out of 539 Pregnant women studied, 32 (5.9%) never attended for antenatal care checkup.Of these 12(21.4%) were in the first trimester, 8(3.0%) in their second , and 12 (5.6%) despite their being in the third trimester. The reasons for not availing antenatal care are presented in Table 1.

Table 1: Reasons of not attending antenatal care

Reasons for not attending ANC	**No.**	**%**
Not all ANC available therefore don't want to go	13	40.6
Distance & less transport	9	28.1
Health workers are rude	6	18.8
No Health problems	3	9.4
Afraid of the law as I'm teenager	1	3.1
Total	32	100.0

More than half (59.4%) of women were reluctant to attend antenatal care as government services seem not ideal in terms of services and behaviour of health providers. Attitude of not attending ANC due to absence of health problems need to be corrected (9.4%). 3.1% did not attend antenatal as age definition seems to prevent from seeking health care.Among 32 pregnant women who did not attend ANC, 14 (43.8%) of women living in villages with a health centre and 18 (56.3%) living in villages without a health centreof being in their third trimester

Frequency of antenatal care visits attended by women is given in Table 2

Table 2: Frequency of antenatal visits by trimester

	Trimester			
Frequency of ANC visits	**1st trimester**	**2nd trimester**	**3rd trimester**	**Total**
	No (%)	**No (%)**	**No (%)**	**No (%)**
1-3 visits	44 (100.0)	259 (99.2)	171 (84.7)	474 (93.5)
4 visits	0 (0.0)	1 (0.4)	25 (12.4)	26 (5.1)
>4 visits	0 (0.0)	1 (0.4)	6 (3.0)	7 (1.4)
Total	44 (100.0)	261 (100.0)	202 (100)	507 (100.0)

Most of the women (84.7%) who are in their third trimester have made only 1-3 antenatal visits, and only 31 (15.4%) could make 4 and more visits.

Quality of ANC services can be assessed by looking at the number of times women received different components of antenatal care during their pregnancy. Utilization and accessibility of some components are still poor and few components of ANC were missing.Nearly half of women who were in their third trimester never bothered to measure their blood pressure & weight more than once. However, it was gratifying to note that women gave importance to frequent abdominal examinations, although41 women out of 507(8%) did not have

abdominal examination even once from their first trimester.It was noted that 36.7% did not test their hemoglobin even when they are in their third trimester,which indicates that those anaemic did not avail of the IFA tablets.

Regarding level of anaemia, the findings show that 15 out of 56 (26.8%), 99 out of 269 (36.8%) and 79 out of 214 (36.9%) are detected to have anaemia; i.e. a total of 193 out of 539, works out to 35.8% .Nearly 90% (173 women) have mild anaemia and 10% have moderate or severe anaemia. 10% of those given IFA tablets do not consume them.Further, more than 60% have not received supplementary nutrition,

Overall, 38.7% did not receive TT injection, 77% of those in the first trimester, 45% of the second rimester and 22% who are in their third trimester.Calcium supplementation recorded the lowest intake as women initiated this service late in their second trimester. 45.4% of women did not consume calcium since their first trimester which is considerably high.Overall, half the women never had their urines tested. Likewise, half never got themselves tested for HIV infection.

Generally, most pregnant women appear to have adequate knowledge about overall antenatal care services, but not on why they are important for their welfare, This is true in terms of the their knowledge and attitudes towards regular consumption of IFA tablets, testing for HIV,urines, and taking TT injections.Nearly 10% feel early registration is not necessary, and over 35% feel that more than 3 ANC is not required unless there are problems.

Home delivery is still a preferred practice among women where 47.2% were in their third trimester, 43.5% were in their second trimester and 37.5% plan to deliver at home even though they were in their first trimester. Reasons for opting for home delivery are given in Table 3

Table 3: Reasons women choose home delivery

REASON	No.	%
Bad road condition,Steep slope area,	54	22.6
Not comfortable delivery in institution	51	21.3
No health complications	18	7.5
Available of Traditional Birth Attendant & quack doctors	34	14.2
Scared of C-section	17	7.1
Dislike the behaviour of health workers	4	1.7
No delivery facility in health centres	7	2.9
Lack of vehicle	48	20.1
No money for transport	6	2.5
Total	239	100

Utilization of antennal care

Summary of utilization of key components of antenatal care is shown in Table 4

Table 4: Utilization Of Antenatal Care Components

ANC COMPONENTS UTILIZED	NEVER	ONCE	MORE THAN ONCE
	Percent(No.)	Percent(No.)	Percent(No.)
BP And Weight Measurements	1.8%(9)	47.3%(240)	50.9(258)
Abdominal Measurements	8.1*(41)	49.5%(251)	42.4(215)
Haemoglobin Testing	36.7%(186)	41.0(208)	22.3(113)
Tetanus Toxoid Injections	38.7%(196)	57.6%(292)	3.7%(19)
Calcium Supplementation	45.4%(230)	40.0%(203)	14.6%(17)
Urine Testing	48.5%(246)	49.11%(249)	2.4%(12)
Hiv Testing	47.1%(239)	52.9%(268)	0.0%(0)

Utilization and accessibility of some components are still poor and few components of ANC were missing.Nearlyhalf of women who were in their third trimester never bothered to measure their blood pressure & weight more than once. BP and weight measurement can be done many times by front line workers without going to the health facility starting from first trimester, several women in the study did not measure their BP and weight even when they are in their 2nd trimester. 41 women out of 507(8%) did not have abdominal examination even once from their first trimester.

More than one-third of pregnant women (36.7%)did not test their hemoglobin even when they are in their third trimester.Regarding level of anaemia, the findings show that 15 out of 56 (26.8%), 99 out of 269 (36.8%) and 79 out of 214 (36.9%) are detected to have anaemia; i.e. a total of 193 out of 539, works out to 35.8%, which is quite high, Nearly 90% (173 women) have mild anaemia and 10% have moderate or severe anaemia.

Regardless of trimester, 9.4% did not consume IFA despite of detected of aneamia.More than 60% have not received supplementary nutrition, which needs urgent investigation of the reasons for noncompliance.Not receiving tetanus toxoid injection (38.7%) during pregnancy need to be investigated and monitored by health workers.Calcium supplementation recorded the lowest intake as women initiated this service late in their second trimester. 45.4% of women did not consume calcium since their first trimester which is considerably high.

Nearly half (48.5%) of women did not test their urine in all their trimester. About half the women(52.9%) had HIV tests donein spite of stigma attached to it;

Knowledge and Attitudes to Antenatal Care

Pregnant women appear to have adequate knowledge about overall antenatal care services.but most of them were ignorant regarding the importance of several ANC components, such the need to attend ANC in the first trimester itself, need for more thn 3 AN visits especially if they have anaemia or other health problems..Knowledge on commencing/initiating of IFA is low despite of being in second and third trimester, as also the duration of IFA consumption.

Half (50.5%) of pregnant women did not know and cannot indicate their hemoglobin level even when they are in their second and third trimester. Many did not know the importance of TT injections or testing for HIV infection.

Opinion of pregnant women on early registration sounds negative, thinking it's not necessary to register during their first trimester, 13.4% of women who were in second trimester had poor attitude compared to women in first and third trimester.Attitude towards subsequent visits for ANC seems negatively high by expressing that it is not required to remember their subsequent visits. Poor attitude is high (41.1%) among women in first trimester compared to women in second and third trimester. Majority (71.6%)of pregnant women expressed that ASHA used to inform them for ANC check up, hence not required to remember by them.

Women expressed that by taking healthy diet (68.8%) and use of traditional medicines (31.2%) will improve their health without consumption of IFA hence not required.Counseling is one of essential aspects that pregnant women should get right from their first trimester, however 12.2% of women did not even when they are in their third trimmest Majority 62.3% of women did not get sensitisation on maternal health issues at any point of time of their motherhood, women in third trimester were expected to be more sensitized, however a significant number did not (56.5%)..

98.7% (532) of women were not able to utilize this health insurance. since the MHIS card is not functioning . Even though women are in their third trimester (37.9%) they were not aware about the entitlements which indicates that women were not informed.Out of 348 (64.6%) of women who are aware of maternal entitlements only 65 (18.7%) benefited from these entitlements 81.3% of women did not get benefit from maternal entitlement even though they were aware about it. The main reasons given by women were not getting proper explaination about the detail of the entitlement (69.9%)followed by not having MCP card and BPL card, no bank account, no voter ID, incomplete check up. Some women are simply did not want to apply as they feel the amount is very less.

Of 539 women interviewed, 133 experienced health problems during their pregnancy period. However, most of them did not seek the help of the HC staff and consulted local practitioners

Reasons that prevent women from seeking health care from health facility were because of the distance (66.7%) and using of home remedy (33.3%).

Even though trained health workers were the majority that pregnant women contacted with, attending to the need of health seekers is still a concern .Women in second trimester were the majority (15%) whom health workers never attended when women needed them, followed by women in third trimester (11%) and women in first trimester (6.8%). Women in first trimester (20.5%) waited for longer time (1 hr or more) at health facility for antenatal check up followed by women in third trimester (16.3%)

Home delivery is still a preferred practice among women where 47.2% were in their third trimester, 43.5% were in their second trimester and 37.5% plan to deliver at home even though they were in their first trimester. Majority (71.1%) of women across trimesters had to walk to a health facility for check up, lacking of transport leads women to walk.

Further analyses by age, gravida, type of family and educational level of parents did not reveal statistically significant differences in utilization, knowledge or attitudes.

IV. DISCUSSION

The major objectives of this research in Meghalaya deal with utilization of maternal and child health services by pregnant and recently delivered women. It is well known that health service utilization depends on several factors(WHO 2016), which includes demand for such services and the availability of personnel and resources to provide these services (Singh 2016; Ensor & Cooper, 2004). Extensive research is published on demand-side determinants such as individual,household, or community characteristics that influence the demand for health services.(Griffiths and Stephenson 2001; Elmusharaff et al 2015)). In contrast,supply-side factors are those characteristics of the health system that exist beyond the control of potential health service users, and would include health facilities, drugs, equipment, finances, human resources, geographic distance, and so on (Peters et al., 2008). Findings from this research have identified deficiencies in both sides of utilization as seen from the Tables and FGDs.

Under the primary health care setup, a health sub-center (HSC) serves as the first point of contact for individuals living in rural areas. A dynamic health centre with necessary supplies and equipment with well trained motivated staff play an important role in bringing about behavioral changes through interpersonal communication, providing a wide range of antenatal, intrapartum and postpartum care that focusses on safe delivery, provision of preventive services, family planning, nutrition, and emergency services (Bhandari & Dutta, 2007). The auxiliary nurse midwife (ANM), the sole female functionary at the HSC level, is largely responsible for implementing maternal health programs in rural India (Malik, 2009;Mavalankar & Vora,2008). Unfortunately, the level of maternal services available at HSCs in most states is still very low (International Institute for Population Sciences, 2017), as seen from the findings of this research as well.

Antenatal care from earliest stages of pregnancy plays a significant part of MCH services(Zuhair and Roy 2017)) for providing the expectant mother with sound advice and help to prevent maternal morbidty and offer advice on nutrition,better hygiene and immunizations(Aga & Williams 2016) . The building blocks of comprehensive health care include not just availability of health services but their access and acceptability by the clients concerned(Simkhada et al 2008)). The findings from this research on low utilization of MCH services, especially antenatal care, is not usual but seen in other developing countries(Dahiru and Mansur 2015;Banke-Thomas et al 2017).

In a national study of tribes in India(Adhikari et al 20160, the utilization of ANC services among Scheduled Tribes women varied from about 4 per cent in Madhya Pradesh and Rajasthan to 10-14 per cent in Chhattisgarh and Odisha. Utilization was highest among those women with level of education 9th class and above (15-28%) and those women who visited health facility for pregnancy confirmation test (9-27%).) Poor utilization appears to be strongly correlated with not only illiteracy and poverty but inadequate knowledge and motivations, pointing out the need for greater interaction by the health centre staff with the families and general public, as seen in other studies(Glenton et al 2013).Based on indepth qualitative research using sixty focus group discussions with rural mothers, their spouses and community health workers, a study in Pakistan(Memon et al 2016) reported low awareness, formidable distances,expense, and poorly functional services were the main barriers reported, while cultural and religious restrictions were lesser reported. For preventive services including antenatal care (ANC), facility deliveries, postnatal care(PNC), childhood immunization and family planning, the main barrier was low awareness.Thus, merely expanding health facility infrastructure expansion without building community awareness, and better training of health centre staff, ASHA workers and other community workers. Many governments, including India, have expanded maternal and child care services in pursuance of attaining millennium development goals 4 and 5 to reduce maternal and infant mortalities(Bryce, Black, & Victoria, 2013).

Apart from providing required resources, most governments have also introduced in rural areas, several incentives in health systems such as pay for performance (Basinga et al., 2011), cash transfers and voucher schemes (Lim et al., 2010) to improve MCH services. In Meghalaya also, the research has shown that there are many MCH interventions to tackle the expenses associated with maternity care services, most notable of these is the Janani Suraksha Yojana (JSY) scheme, implemented by the National Rural Health Mission (NRHM) in 2005 to provide underprivileged pregnant women with cash assistance . It is disappointing to note, however, that many of these schemes do not seem to be attractive and poorly used. Qualitative research clearly showed that the majority of women indifferent to these incentives as they felt there were many beauracratic obstacles and the benefits were meagre. While these initiatives are useful and required, the assessment of how

successful and impactful these programs are should be documented in the scientific literature, to guide future MCH programmes in India There is a great need to carefully evaluate these schemes, modify and remove bottlenecks and corruption inherent in such programmes.(Ogbo et al 2019)

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